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Physical Therapy & Wellness

Registration Form

PATIENT NAME (as on insurance card)

_____

First Last Middle initial Date of birth

_____

Address Street Apt.# City State Zip

Phone: H (_____) - (_____) - (_____) C (_____) - (_____) - (_____)

Emergency Contact: _____
Name Relationship Phone #

Email Address: _____

Physician Name: _____

Please let us know how you heard about PRO-TEK Physical Therapy:
_____

Insurance information:

Primary insurance:_____Secondary insurance:_____
Policyholder: _____Policyholder:_____
Policyholder DOB:_____Policyholder DOB:_____
Relationship to policyholder:_____Relationship to policyholder:_____
ID Number:_____ID Number:_____

No Fault or Worker's Compensation Information:

Insurance Company:_____Claim #:_____
Adjustor's name:_____Adjustor's phone #:_____
Address:_____Date of accident:_____
Referring Physician:_____Primary Care Physician:_____
Date of Injury:_____Date of surgery:_____

Patient or guardian signature: _____

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Weight _____ Height _____ Have you fallen ill in the past year?
YES or NO
If **YES**, how many times? _____
On a scale from 1-10 (Least Afraid **1** -- Somewhat Afraid **5** -- Most Afraid **10**) **Rate your FEAR OF FALLING while doing the following activities:**

Activity	Score
Taking a bath or shower	
Reaching into cabinets or closets	
Walking around the house	
Preparing meals not requiring carrying heavy objects	
Getting in and out of bed	
Answering the door or telephone	
Getting in and out of a chair	
Getting dressed and undressed	
Personal grooming (ex: washing your face)	
Getting on and off the toilet	
TOTAL:	

Please list ALL past surgeries and corresponding dates:

_____

_____

Please circle any of the following treatments you have received this past year:
Chiropractic Physical Therapy Occupational Therapy Speech Therapy
Acupuncture Massage Therapy Cortisone Injections Epidural Injections
If yes, how many visits? _____
Patient or Guardian Signature: _____

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Please check if you have any history of the following conditions:

___ Allergies ___ Cancer ___ Heart Attack ___ Pregnancy

___ Anemia ___ Chest Pains ___ High Blood Pressure ___ Radiation

___ Anxiety ___ Concussion ___ High Cholesterol ___ Rheumatoid Arthritis

___ Asthma ___ Dizziness ___ Metal Implants ___ Stroke

___ Arthritis ___ Diabetes ___ Low Blood Pressure ___ Seizures

___ Balance Problems ___ Epilepsy ___ Motor Vehicle Accident ___ Substance Abuse

___ Blood Clot ___ Falls ___ Osteoporosis ___ Thyroid Dysfunction

___ Brian Injury ___ Headaches ___ Pacemaker ___ Ulcer

Please list any other past medical history not listed above:

_____

_____

Please list all prescription and over-the-counter medications you are currently taking. Please also include dosages and times per day.

_____

Patient or Guardian Signature:

_____

_____

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CONSENT AGREEMENT, PAYMENT AUTHORIZATION, CERTIFICATION OF INFORMATION: (PLEASE READ AND INITIAL):

Assignment of Insurance Benefits **Initial:_____**

I certify that my insurance information is correct to the best of my knowledge. I also certify that I, and/or my dependents, have insurance coverage with _____ and will directly assign all insurance benefits to ProTEK Physical Therapy PLLC, if any, otherwise payable to me for services rendered. If I receive a check directly from my insurance company in error, I will promptly deliver it to ProTEK Physical Therapy PLLC. I authorize the use of my signature on all insurance submissions. ProTEK Physical Therapy may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Guarantee of Payment **Initial:_____**

I understand that I am financially responsible for all charger whether or not they are paid by insurance. I understand that all payments designated as "patient responsibility" such as co-insurance, copayments, and deductibles, are due and payable at the time of service upon check-in or statement receipt. I understand that insurance verification and pre-authorization are not a guarantee of coverage. I guarantee that I will pay the amount deemed "my responsibility" by my insurer and/or any unpaid claims by the statement due date.

Cancellation/No-Show Policy **Initial:_____**

I understand that ProTEK Physical Therapy requires 24 HOURS NOTICE prior to my scheduled appointment time in the event of a cancellation. I acknowledge and agree to pay the $50 FEE FOR LATE CANCELLATIONS/NO-SHOW upon check-in at my next visit. In the event that I do not have any future appointments, I agree to pay any and all fees incurred upon receipt of a statement from ProTEK Physical Therapy.

For MEDICARE PATIENTS ONLY **Initial:_____**

I certify that the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign benefits payable for physical therapy services to ProTEK Physical Therapy PLLC.

Certification of Information **Initial:_____** I CERTIFY THAT THE INFORMATION I HAVE PROVIDED TO ProTEK PHYSICAL THERAPY PLLC FOR PAYMENT INCLUDING BUT NOT LIMITED TO, RELATED ACCIDENTS, INJURIES, ILLNESSES OR THEIR INSURERS IS ACCURATE AND TRUTHFUL.

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INFORMED CONSENT FOR PHYSICAL THERAPY:

Dear Patient,

It is our duty to inform you of what to expect with your physical therapy treatment, as well as any risks and options of treatment.

Physical therapy treatment at Pro-Tek Physical Therapy is hands-on and very individualistic. Therefore, it is not always possible to predict your response to treatment. We are not able to guarantee precisely what your reaction to a particular treatment might be. In addition, there is no guarantee that our treatment will help your condition. As with any medical treatment, there is always the risk of a condition being aggravated or worsening. You have the right to ask your physical therapist what type of treatment may be used and the potential adverse effects of such treatment. You can decline any part of your treatment before or during your session.

Manual therapy with hands on skin to skin contact is often a part of a physical therapy treatment session. During treatment, the physical therapist may come in contact with various parts of your body including, but not limited to: face, neck, shoulder, arm, underarm, chest area, stomach, back, sacrum, inner and outer thigh, pelvis, buttock, leg, ankle, and foot. You have the right to ask your physical therapist what type of treatment you will be receiving. You can decline any part of your treatment before or during your session at any time.

Therapeutic exercises are often part of a physical therapy treatment session. There are always risks associated with therapeutic exercises. Please ask your physical therapist any questions or concerns you may have regarding any of the exercises you are asked to perform.

I acknowledge that my treatment program has been explained by a physical therapist at Pro-TEK Physical Therapy PLLC, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

_____ _____ _____

Patient Name Patient Signature Date

Patient or Guardian Signature: _____

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ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits - Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and Law Firm (if applicable) (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Institute and necessary litigations and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- Discuss or divulge any of my personal health information or that of my dependent with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as if the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including copayments, coinsurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that i may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and.or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5091(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the provider and his authorized representatives by email and my email address is: _____@____. I understand I can revoke with authorization in writing at any time. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____	_____	_____
Patient Name	Patient Signature	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, (Print Name:) _____, have received a copy of this office's Notice of Privacy Practices upon arrival to the office for my initial physical therapy visit.

_____
Patient Name

_____ _____
Patient Signature Date

_____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other:

_____

_____

Patient or Guardian Signature: _____